Cultural & Linguistic Services

in the

Healthy Families Program

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Managed Risk Medical Insurance Board

MANAGED RISK MEDICAL INSURANCE BOARD (MRMIB)

Healthy Families Program (HFP)

MRMIB provides and promotes access to affordable coverage for comprehensive, high quality, cost effective health care services to improve the health of Californians.

Lesley Cummings
Executive Director
Managed Risk Medical Insurance Board

Shelley Rouillard
Deputy Director
Benefits and Quality Monitoring Division

Ruth I. Jacobs, R.N.
Assistant Deputy Director
Benefits and Quality Monitoring Division

Renee Mota-Jackson
Manager
Benefits and Quality Monitoring Division

Alba Quiroz-Garcia
Research Program Specialist
Benefits and Quality Monitoring Division

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Contra Costa Health Plan
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Health Plan of San Joaquin
Health Plan of San Mateo
Inland Empire Health Plan
Kaiser Permanente North & South
Kern Family Health Care
L.A. Care
San Francisco Health Plan
Santa Barbara Regional Health
Santa Clara Family Health
Ventura County Health Plan

The HFP Dental Plans
Access Dental
Delta Dental
Health Net Dental
Premier Access
Safeguard Dental
Western Dental

The HFP Vision Plans
Eye Med
Safeguard Vision
Vision Service Plan (VSP)

Patient Advocates
California Pan Ethnic Health Network (CPEHN)

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Executive Summary

Background

Since 1998, the Managed Risk Medical Insurance Board (MRMIB) has required all Healthy Families Program (HFP) participating plans to report annually on the services they provide to meet the cultural and linguistic needs of their members. MRMIB contracts with 34 health, dental and vision plans to provide services to children enrolled in the HFP.

The HFP population is very diverse, with Latinos representing more than half (57%) of the enrolled population. Whites and Asian/Pacific Islanders each make up about 11% of the HFP population, with African-Americans comprising about 2% of the population. Because of this diversity, it is crucial that the HFP plans provide language assistance service and culturally competent care to their limited-English proficient (LEP) members.

2006-2007 Cultural and Linguistic Services Survey

This report summarizes plans' responses to the 2006-2007 Cultural and Linguistic (C&L) Services Survey. Every plan responded to the C&L Services Survey. Highlighted throughout the report are "innovative" or "best practices" that draw attention to some of the unique ways in which plans are serving their LEP members.

The HFP enrollment application is the primary source of information on HFP members' language preference. About half of the plans report that they identify language preference also during "Welcome Calls" placed to new enrollees. Most, but not all, HFP plans inform their contracted providers of the language preference of their assigned members. Plans typically provide this information when they notify a provider of a newly assigned member who has expressed a language preference.

Plans must inform their members of the availability of no-cost interpretation services and they do so in a variety of ways. All plans report that they provide information on interpreter services in the Evidence of Coverage booklets sent to each member. Many report that they reiterate this information in "Welcome Calls" or through member newsletters. Some plans provide "I Speak" cards to their members that inform the provider of the member language preference and advise the member on how to access interpretation services through the plan.

Interpretation services are offered through telephone language lines, member services departments and through contracts plans have with vendors that provide face-to-face interpretation services. Some plans report that they use community-based organizations to provide interpretation and translation services to LEP members. In addition, most plans report that they arrange for language assistance at providers' offices if requested to do so by members. About half of the plans report that they conduct new member orientation sessions and health education classes in languages other than English.

Almost all plans hire staff with conversational fluency in languages other than English. Many plans assess their staff's language proficiency at the time of hire and some continuously assess the language proficiency of their staff. About half of the HFP plans report that they hire staff with bilingual fluency in medical terminology and/or provide medical dictionaries and glossaries for interpreters to use.

Plans must translate their written materials into Spanish and any other language that meets a "threshold" definition established in the HFP contract. Nearly all plans report that they contract with a certified translation company and then often use a different translation editor/proofreader to review the translated document. About one-third of HFP plans conduct "back translations" where translated material is translated back into its original language to ensure accuracy.

Plans report a variety of methods to train their providers and staff on the availability of interpretation services. Plans report that they distribute information through newsletters, at departmental meetings and workshops, and at new employee orientation sessions. Some sponsor or participate in community cultural awareness events. Most plans rely on member feedback on language assistance services to monitor provider compliance. Two-thirds of plans report that they audit provider offices to monitor implementation of language assistance programs and services.

HFP contracts also require plans to develop internal systems to meet the C&L needs of their members. Nearly all plans report that they have a special office or designated staff to facilitate the integration of cultural competency into the organization. Most plans report that they develop recruitment/retention initiatives to ensure that staff reflect the community served by the plans. More than half of HFP plans report that their mission incorporates cultural competency and conduct training sessions to support cultural understanding. Only about one-third of plans report that they assess providers' cultural competence "on a regular basis."

The primary method plans use to evaluate their C&L processes is through member complaints and grievances. About half of the plans review responses to questions on member satisfaction surveys related to language access, and about half report that they review clinical/utilization data for health disparities.

Conclusion

Reponses to the C&L survey provide MRMIB with a snapshot of how plans are meeting the needs of their LEP members. While it appears that most plans are meeting the basic contract requirements, there is more that they can do. A number of plans have developed innovative methods to address the C&L needs of their LEP members while others still fall behind in meeting basic language access requirements.

MRMIB will work with HFP plans that are not meeting the C&L requirements to discuss issues and/or barriers experienced by the plans, share strategies from other plans, and develop and monitor corrective action plans to improve services to LEP members.

Introduction

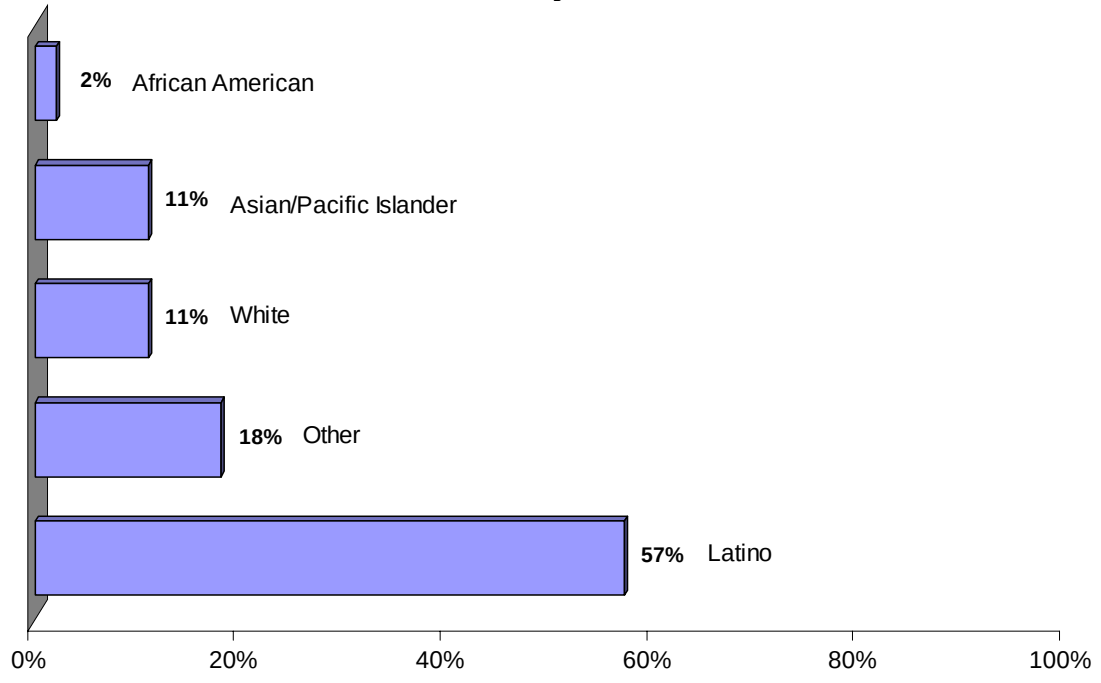
The California Managed Risk Medical Insurance Board (MRMIB) Healthy Families Program (HFP) provides low cost health, dental and vision insurance to children in families with income between 100%-250% of the federal poverty level. MRMIB contracts with thirty-four (34) insurance plans to provide health services to children enrolled in the HFP. Twenty-five (25) health plans provide comprehensive health coverage through Health Maintenance Organizations (HMO) and Exclusive Provider Organizations (EPO). Six (6) dental plans provide preventive and restorative dental services. Three (3) vision plans provide routine eye care. As of August 30, 2007, there were 831,939 children enrolled in HFP. Enrollment is nearly equally divided between males (51%) and females (49%).

Ethnicity of the HFP Members

The HFP population is very ethnically diverse. Latino members represent more than half (57%) of the HFP enrolled population. Whites and Asian/Pacific Islander members each make up about 11% of the HFP population. African-Americans comprise about 2 percent of the HFP member base. All other groups, including those not disclosing their ethnicity, make up the remaining 18 percent.[1] See Chart 1.

Chart 1

Ethnicity in the HFP

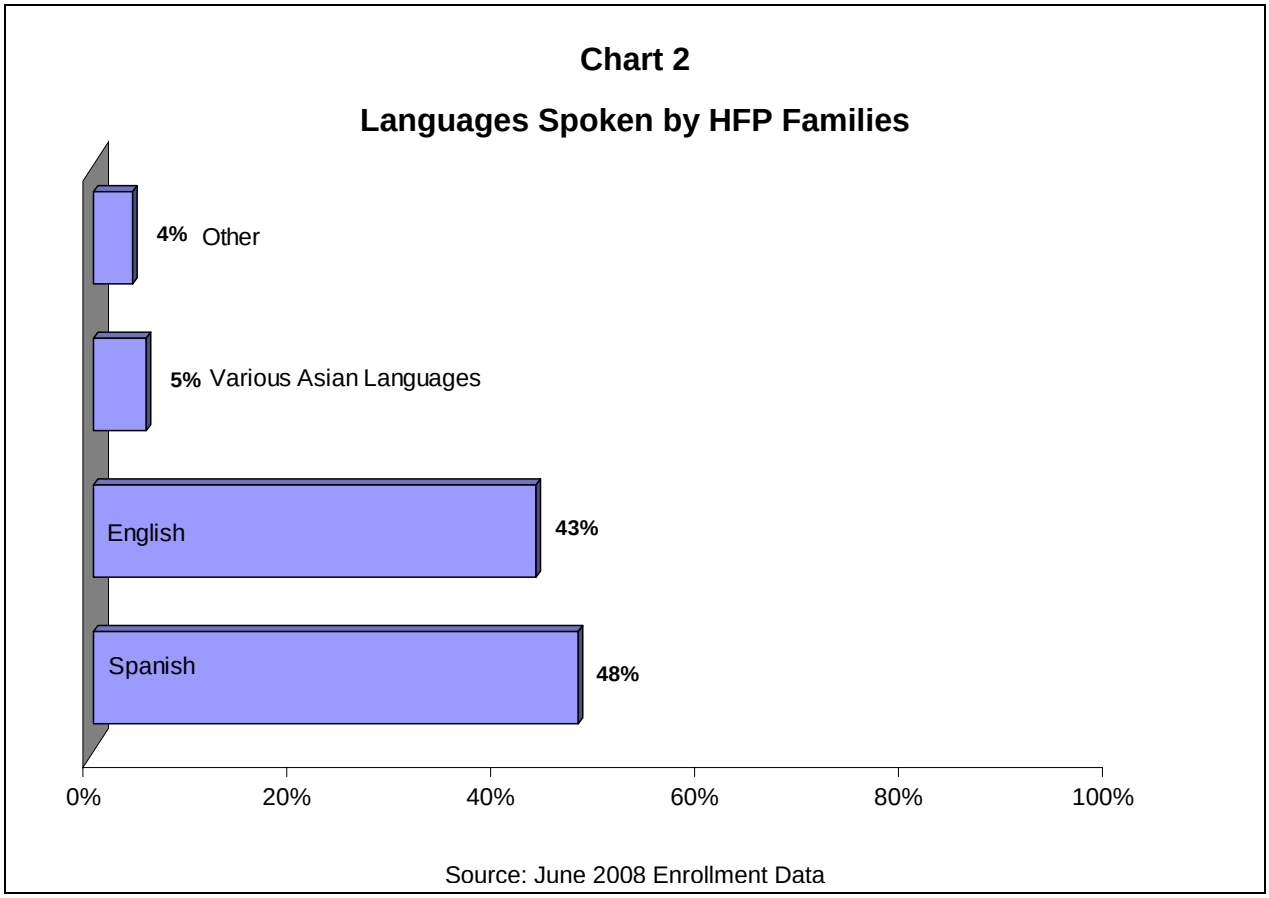


Source: June 2008 Enrollment Data

[1] Other includes: American Indian, Alaskan Native and decline to disclose.

Languages Spoken by HFP Families

The majority of HFP applicants[2] speak the following languages: Spanish (47.6%), English (43.4%), various Asian languages[3] (5.2%), and Other[4] (3.9%). This information is obtained from the application forms in which applicants are asked to identify their preferred written and spoken language. The information identifying their language preference is transmitted to the plans. See Chart 2.



The diversity of the HFP population makes it crucial that HFP health, dental and vision plans comply with requirements to provide language assistance services and culturally competent care.

Federal Requirements for Services for Persons with Limited English Proficiency

Title VI of the federal Civil Rights Act of 1964 which prohibits recipients of federal funding from discriminating against persons based on race, color, or national origin, sets out standards for equal access and participation in federally funded programs for LEP

[2] Applicants in HFP are parents, guardians, and caretakers, not children.
[3] Asian languages include: Vietnamese, Chinese, Japanese, Cambodian, Thai, Tagalog, Hmong, Cantonese, and Korean.
[4] HFP applicants speak a number of other languages including Russian, Farsi, Armenian, and Italian.

individuals. Because MRMIB receives federal funding for the HFP through the State Children's Health Insurance Program (SCHIP), the standards of Title VI apply to all HFP participating plans. In developing the contract requirements for HFP plans, MRMIB staff worked with staff at the Office of Civil Rights to assure that HFP contract language regarding cultural and linguistic services complies with Title VI requirements.

In addition to complying with Title VI of the Civil Rights Act, contracts between MRMIB and HFP plans require plans to conduct specific cultural and linguistic activities including:

- Assessing members cultural and linguistic needs in a Groups Needs Assessment (GNA) every four years
- Providing interpretation services
- Assigning primary care providers to LEP members
- Translating written materials such has coverage booklets, and health education materials
- Providing alternative formats of translated written materials
- Training plan staff and providers
- Monitoring language assistance services
- Improving plans' C&L internal systems

Every year, since the inception of the HFP, plans have reported how they meet these requirements.

State Requirements for Language Assistance Programs

Senate Bill 853 (Chapter 713, Statutes of 2003) which was sponsored by the California Pan-Ethnic Health Network (CPEHN) and other advocacy groups amended the Knox-Keene Act and the Insurance Code to require the Department of Managed Health Care (DMHC) and the Department of Insurance (DOI) to establish Language Assistance Program regulations for health, dental and vision plans. The regulations were required to address the provision of language assistance, standards for assessment of member needs, interpretative services, and translation of key documents. DMHC published the regulations on February 23, 2007. DOI published them shortly thereafter. Thirty (30) HFP plans are licensed by DMHC and four (4) plans are licensed by DOI.

Many HFP C&L requirements are included in the DMHC Language Assistance Program regulations. Some of these are:

- Assessing the cultural and linguistic needs of plan members
- Informing plan members of the availability of free interpretation services and how to access such services in non-English languages
- Translating plan informational materials and notices
- Training plan staff on cultural and linguistic services
- Monitoring plans' language assistance programs.

MRMIB staff is comparing the specific C&L standards in the HFP contract with the DMHC regulations to determine whether MRMIB needs to modify its contract requirements and/or monitoring functions.

Group Needs Assessment

HFP contracts require plans to complete a Cultural and Linguistic Group Needs Assessment (GNA) of their members every four years. The plans are also required to provide member representatives the opportunity for input on the C&L GNA. The GNA serves as a foundation for the plans' C&L activities. Plans are required to complete the following and include their findings in the GNA report:

- A demographic profile of the plan's members by ethnicity and language. The development of the profile includes examining the language preference of the plan members as well as other data related to the health risks and cultural beliefs and practices of the plan members.
- An assessment of the plan's internal systems to address the C&L needs of its member. This includes assessing the plan's capacity to provide linguistically appropriate services.
- A review of internal data as it relates to C&L competency including:
    - Complaints and grievances
    - Member survey results
    - Plan staff diversity and language ability
    - Policies and procedures
    - Staff and provider training
    - Utilization and outcome data analyzed by race, ethnicity and primary language, if feasible.

The plans are required to compare their internal data to external data benchmarks and trends.

Plans also must develop a plan that outlines the proposed services to be improved or implemented as a result of the assessment findings. Plans are required to address any cultural and linguistic barriers they have identified and describe how they will work toward reducing racial, ethnic, and language disparities.

HFP plans submitted their 2007 GNA reports to MRMIB in September 2007. MRMIB staff are reviewing the reports and will present the results of that review to the Board in early 2008.

Cultural & Linguistic Services Survey for 2006-07

Since 1998, MRMIB has required all HFP participating plans to report on services provided to meet the cultural and linguistic (C&L) needs of their members.

The C&L Services Survey for 2006-07 is intended to assist MRMIB in monitoring plan compliance with language assistance requirements and assessing the progress plans are making in implementing cultural and linguistic activities. Results from the survey will also inform advocates, policymakers, and other stakeholders on how plans meet the C&L needs of their HFP members.

MRMIB redesigned the survey document for 2006-07. The survey uses guided questions to promote more consistency in plan responses. California Pan-Ethnic Health Network (CPEHN) as well as HFP plans assisted MRMIB staff in redesigning the survey. The survey instrument is attached as Attachment A.

The survey contains questions about the following plan activities:

- Provision of Linguistic Services
- Translation of Written Materials
- Plan Staff and Provider Training
- Monitoring of Language Assistance Services
- Internal Systems Development

Provision of Linguistic Services

Assessing Members' Cultural and Linguistic Needs

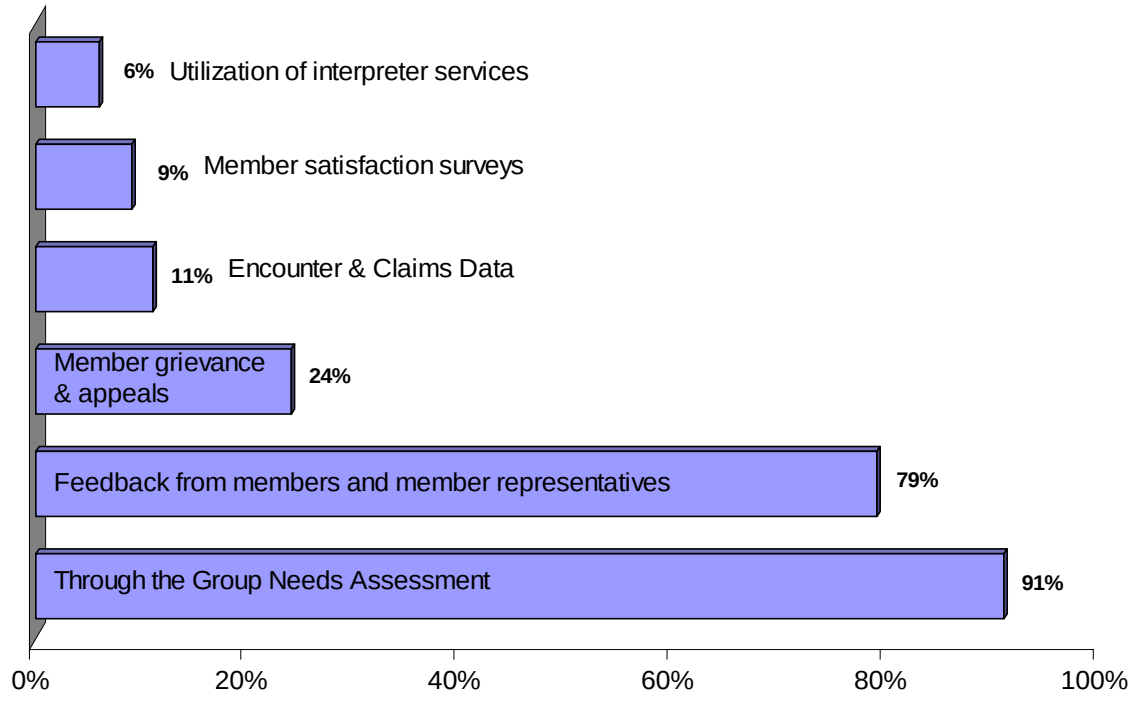
HFP contracts require plans to assess the cultural and linguistic needs of their members.

The primary method (91%) that plans use to assess the C&L needs of HFP members is through the GNA plans are required to complete every four years. More than three quarters (79%) of plans use feedback from members and member representatives during plan meetings and member feedback from phone, mail or web surveys. About one quarter (24%) of plans use member grievances and appeals data to assess members' C&L needs.

Chart 3 identifies the methods plans use to assess the C&L needs of their members.

Chart 3

Assessing the C&L needs of HFP Members



Source: 2006-07 HFP C&L Survey

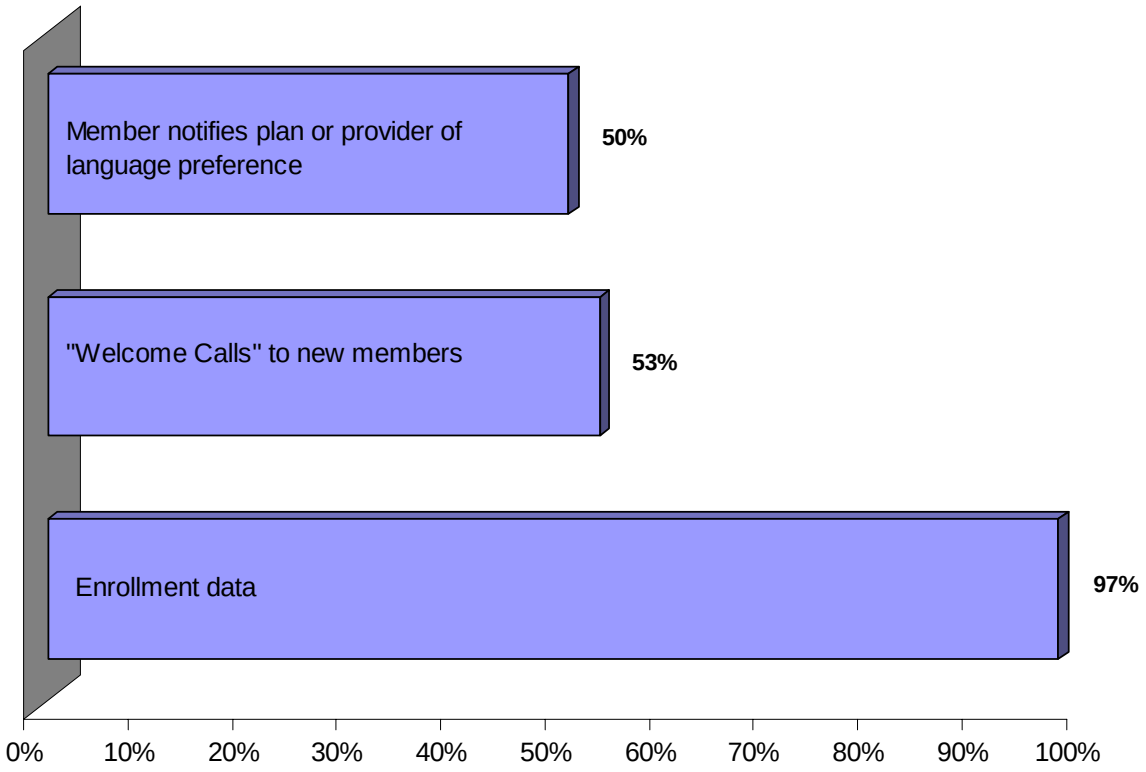
Identifying Member Language Preference

Almost all plans (97%) obtain information about members' language preference from the enrollment application. In addition, about half (53%) identify language preference during welcome calls to new members, and half (50%) identify language preference when members contact the plan or during the initial doctor's office visit.

Chart 4 identifies the methods used by plans to identify member language preference.

Chart 4

Methods Used by Plans to Identify Member Language Preference



Source: 2006-07 HFP C&L Survey

Innovative and/or Best Practice

Molina Health Care:	Case management, disease management and other program staff identify language preference when they contact members.
San Francisco Health Plan:	Member service representatives confirm language preference during any contact with members.

Informing Providers of Member Language Preference

HFP collects a member's language preference data from the enrollment application. Once the individual is enrolled in the HFP, language preference information is transmitted to the selected plan.

Seventy-nine percent (79%) of plans inform providers of members' preferred languages. Twelve percent (12%) of plans indicate that providers can call the plan to ascertain a member's language preference. Three plans report that they do not have a mechanism to inform providers of members' language preference.

Table 1 identifies the four most common methods plans use to inform providers of HFP members' preferred language.

Table 1

How Plans Inform Providers of Member Language Preference	
Monthly eligibility reports with member language preference identified.	Provider contacts plan to obtain member specific information.
New enrollee notification with member language preference information.	Providers access the plan's secure website to obtain member language preference data.

Source: 2006-07 HFP C&L Survey

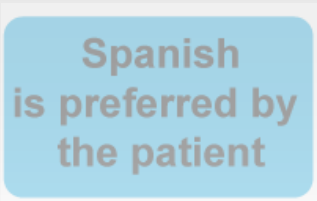
Innovative and/or Best Practice

Santa Clara Health Plan: All new providers are given a manual that includes Interpreter Quick Reference Cards and Language Identification Cards that instruct members to "Point to your language and an interpreter will be provided to you at no cost."

Recording HFP Member Language Preference

All HFP plans report that they instruct providers to record the language preference of members as well as requests and refusals for interpretive services in each member's medical record.

Methods plans use to ensure provider compliance include:



Patient chart label identifying member language preference.

- Giving providers and their staff labels for patient charts that identify member language preference *(see right).*
- Incentive programs to reward providers that identify and document member language preference and requests and refusals of interpretive services.
- Training providers to document the member language preference and request and refusals of interpretive services in each member's medical record.
- Provider audits/facility site reviews that check for documentation of member language preference information and request and refusals of interpretive services.

Innovative and/or Best Practice

The following plans report that they have implemented incentive programs to reward provider offices that affirmatively identify the language preference of members and document those preferences in the member medical records:

Care 1st	Santa Clara Family Health Plan
Community Health Plan	Health Net Dental

Providing Interpretation Services

HFP plans are required to provide the following information to members:[5]

- Availability of no-cost interpreter services.
- The right not to use family members, friends or minors as interpreters.
- The right to request and receive interpretive services from a qualified professional interpreter.
- The right to file a complaint or grievance if linguistic needs are not met.
- The right to request an interpreter during medical discussions with providers.
- The right to receive plan materials in Spanish and any other plan threshold language.[6]

[5] HFP Contract, Exhibit A, Item III.C.1.e.

Innovative and/or Best Practice

Contra Costa Health Services: The plan gives providers a brochure which indicates how to access interpretive services in a simple "step-by-step" method. The brochure lists steps to access the following interpretive services: telephone interpreting, face-to-face interpreters, American Sign Language and general translation services.

No Cost Interpretive Services

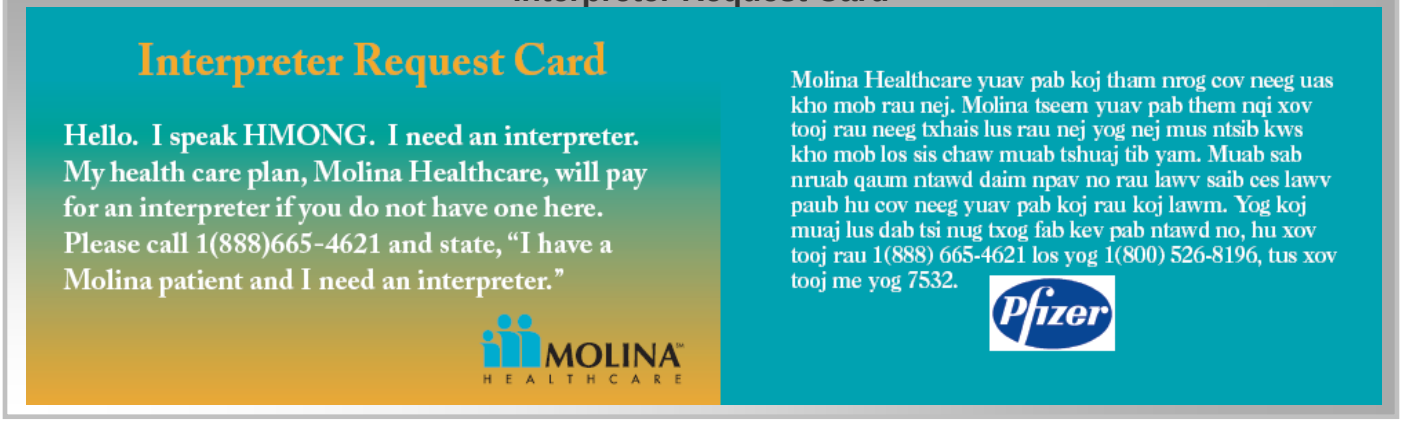
All plans include information on the availability of no cost interpretive services in the annual Evidence of Coverage (EOC) information sent to members. Nearly all (97%) plans report that information on language assistance services is reiterated in member "welcome calls" and "welcoming newsletters." Some plans let members know about the availability of interpretive services through:

- Member orientation sessions
- Health education classes
- Plan websites
- Translated signs at member points of contact, such as provider office reception
- Community Advisory Committees (CACs) [7]
- Nurse advice lines
- Member ID card with the "Right to Use Interpreter" text or Interpreter Request Card *(See Interpreter Request Card).*

[6] HFP Contract, Exhibit A, Item III.C.2.a. states, "Translation of these materials shall be in the following languages: Spanish, and any language representing the preferred mode of communication for the lesser of five percent (5%) of the Contractor's enrollment or 3,000 members of the Contractor's enrollment in the Program."

[7] For example: Health Net maintains seven CACs in different regions of the state that reflect the diversity of the areas they represent. Materials are presented at the CAC for input and recommendations. Health Net utilizes the CACs to assure that the materials produced consider the linguistic and cultural needs of Health Net's members.

Interpreter Request Card



The right side of the card instructs the Hmong patient on how to obtain interpreter services. The English translation is, *"Molina Healthcare will help you talk to your doctor or pharmacist. Molina will also help pay the cost for an interpreter when you see the doctor or the pharmacist. Give this card to the health care workers so they can help call an interpreter to help you. If you have any questions regarding these services, call 1-888-665-4621 or 1-800-526-8196 Ext #: 7532."*

Innovative and/or Best Practice

The following plans reported that they provide their members with Interpreter Request Cards or a Member ID card with the "Right to Use Interpreter" text:

- Alameda Alliance
- Blue Cross EPO & HMO
- Blue Shield EPO & HMO
- Care 1st
- Community Health Plan
- Contra Costa Health Plan
- Kern Family Care
- L.A. Care
- Molina Health Care
- Santa Clara Family Health Plan
- Western Dental

Right Not To Use Family Members, Minors or Friends as Interpreters

HFP plans can not require or encourage members to use family members, minors or friends as interpreters. Plans use the methods identified above to encourage members to use no-cost interpreters and thus avoid using family members, minors or friends. Plans also provide training and establish procedures to inform their contracted providers about not requiring members to use family members, minors or friends as interpreters.

The HFP plan contract allows minors to be used as interpreters only under extraordinary circumstances such as medical emergencies. None of the plans reported any extraordinary circumstances when minors were used as interpreters.

Availability of Linguistic Services Information at Provider Offices

Nearly all plans (94%) report that they list the language capabilities of their providers in the provider directory members receive. More than eighty percent (82%) of plans report that they list the language capabilities of their providers on the plans' websites.

Innovative and/or Best Practice

Kaiser: Some of the plan's facilities have adopted the use of various formats of "I Speak" identification badge labels to identify qualified bilingual staff.

Twenty-four (24) Hour Access to Interpreter Services[8]

Almost all (97%) HFP plans report using a telephone language line to provide 24-hour access to language assistance services.[9] In addition, three-quarters of the plans (74%) report that their member services departments provide 24-hour interpretive services. About two-thirds (68%) of HFP plans use face-to-face interpreters. About one-third (36%) use community-based organizations (CBOs) to provide interpretation and translation services.

Innovative and/or Best Practice

Care 1st: Plan uses the International Rescue Committee, Inc. to provide translation and cultural orientation services for LEP members.

Community Based Organizations (CBOs)

Some plans utilize CBOs to provide the following services to members:

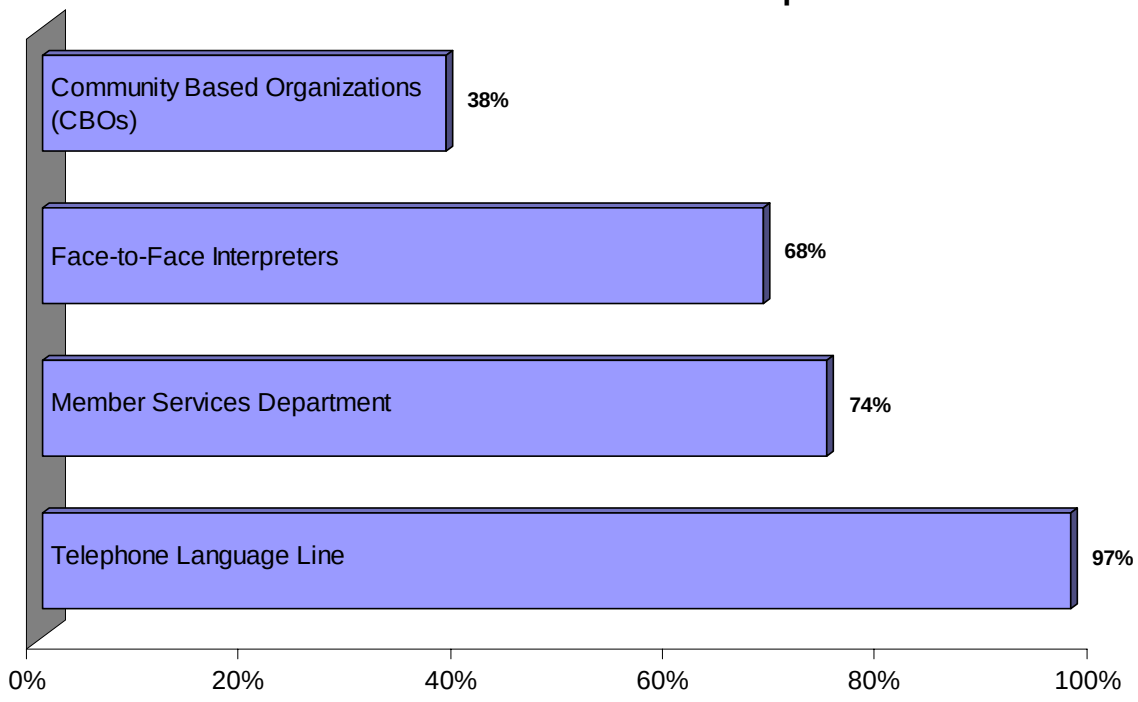
- Culturally competent translations of written material
- Interpreter services during medical appointments
- Research on health promotion, disease prevention, and health disparities.

[8] HFP Contract, Exhibit A, Item III.C.1.b
[9] Only Eye Med reports not providing 24 hour access to interpretive services.

Chart 5 identifies the methods plans use to ensure HFP members have 24-hour access to interpreter services.

Chart 5

How Plans Provide 24-Hour Access to Interpretive Services



Source: 2006-07 HFP C&L Survey

Plans reported that face-to-face interpreters were not feasible when:

- Member arrives more than one hour late to their appointment because the interpreter leaves after waiting for one hour.
- Member did not request the interpreter ahead of time for the appointment. Most plans require 24 to 72 hour notice.
- Member receives care out of the service network of the plan
- Member communicates incorrect appointment time information or provider address.

Other methods reported by plans to ensure 24-hour access to interpretive services include:

- Nurse Advice Phone Lines
- After Hours Answering Services
- TTY/TDD lines for hearing or speaking-impaired members.

Accessibility of Interpretation Services at Medical / Non-Medical Points of Contact

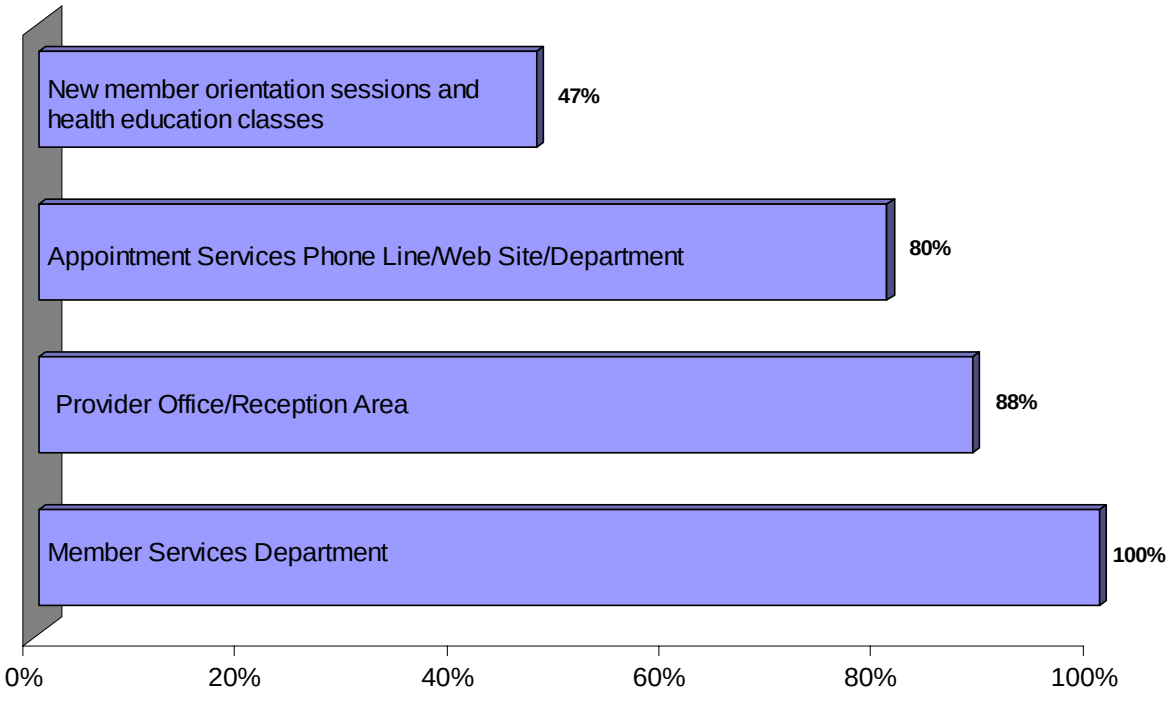
The HFP contract requires plans to provide HFP members access to interpretive services at medical and non-medical points of contact.

All plans provide access to interpretive services through language line phone services. All plans report that their member services departments have access to interpreters. Most plans (88%) arrange for language assistance at provider offices. Eighty percent (80%) of plans have access to interpreters or translated information on their appointment services phone line/web site/department. Almost half of plans (47%) report they conduct new member orientation sessions and health education classes in languages other than English.

Chart 6 identifies medical and non-medical points of contact where plans make language assistance available.

Chart 6

Language Assistance at Non-Medical Points of Contact



Source: 2006-07 HFP C&L Survey

Other points of contact where language assistance is available include:

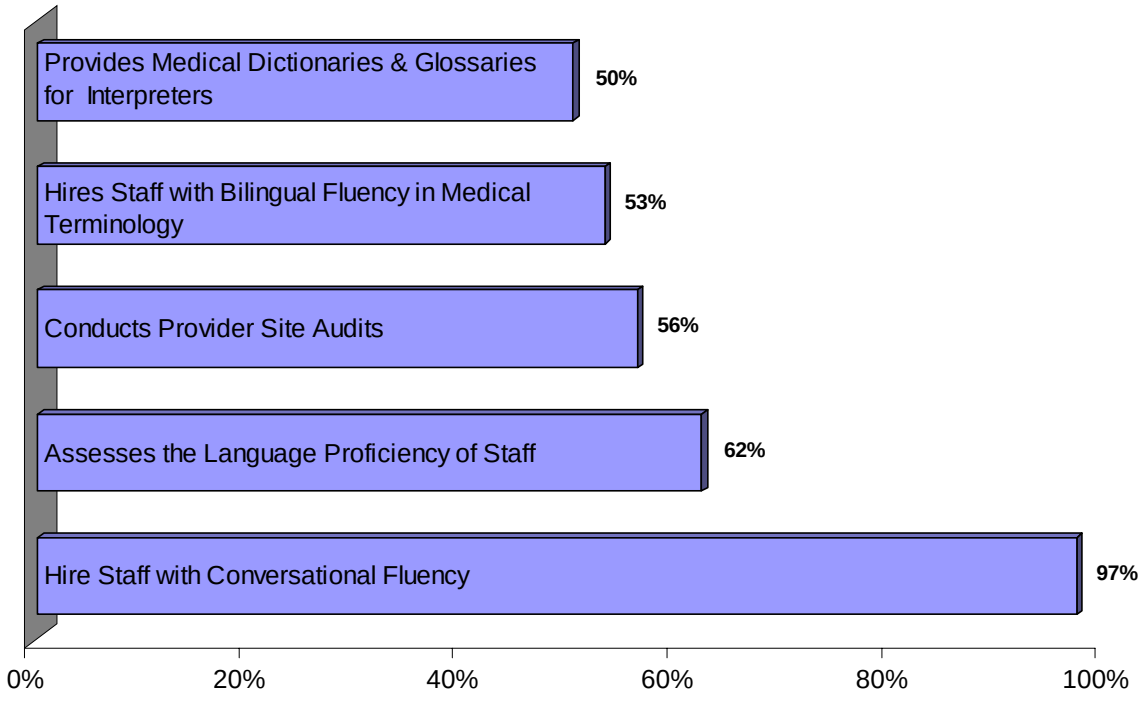
- "Welcome Calls" to new members
- Ancillary providers such as laboratories and imaging centers
- Pharmacies
- Community advisory meetings.

Almost all plans (97%) hire staff with conversational fluency to ensure language access for members at the plans customer service departments. More than sixty percent (62%) of plans assess the language proficiency of their staff upon hire and some plans continuously assess the language proficiency of their staff. More than half (56%) of HFP plans audit patient charts and provider office procedures to ensure compliance with plan C&L policies. Others hire staff with bilingual fluency in medical terminology; and half report that they provide interpreters with medical dictionaries.

Chart 7 identifies the methods that plans use to ensure HFP members have access to interpretive services at medical and non-medical points of contact.

Chart 7

Ensuring Proficiency of Language Assistance



Source: 2006-07 HFP C&L Survey

Innovative and/or Best Practice

Kaiser:	At the time of enrollment, all member demographic information, including language preference, is uploaded into the plan's eligibility and enrollment system. This database is shared with the plan's providers and gives providers real-time access to members' language preference.
Kern Family Health Care:	The plan uses "mystery callers" to verify language capabilities of plan staff and contracted provider office staff.
L.A. Care:	The plan uses a hand-set phone adapter that allows providers and patients to access language services via telephonic dual headsets or handsets when a bilingual health care provider or on-site interpreter is not available. A unique feature of this system is that providers and patients need not pass a telephone or headset back and forth nor use a speaker phone. L.A. Care has installed these handsets at traditional and safety net (T&SN) clinic sites, with the goal of implementing their use in all T&SN clinics contracted with the plan.

Primary Care Physician Assignment

The majority of HFP participating health and dental plans require members to select a Primary Care Physician (PCP) from whom they receive basic health or dental services.[10] Members who do not select a PCP are assigned to one by their plan. More than eighty percent (85%) of plans report that they take member language preference into account when assigning members to PCPs.

Provider Selection via HFP Website

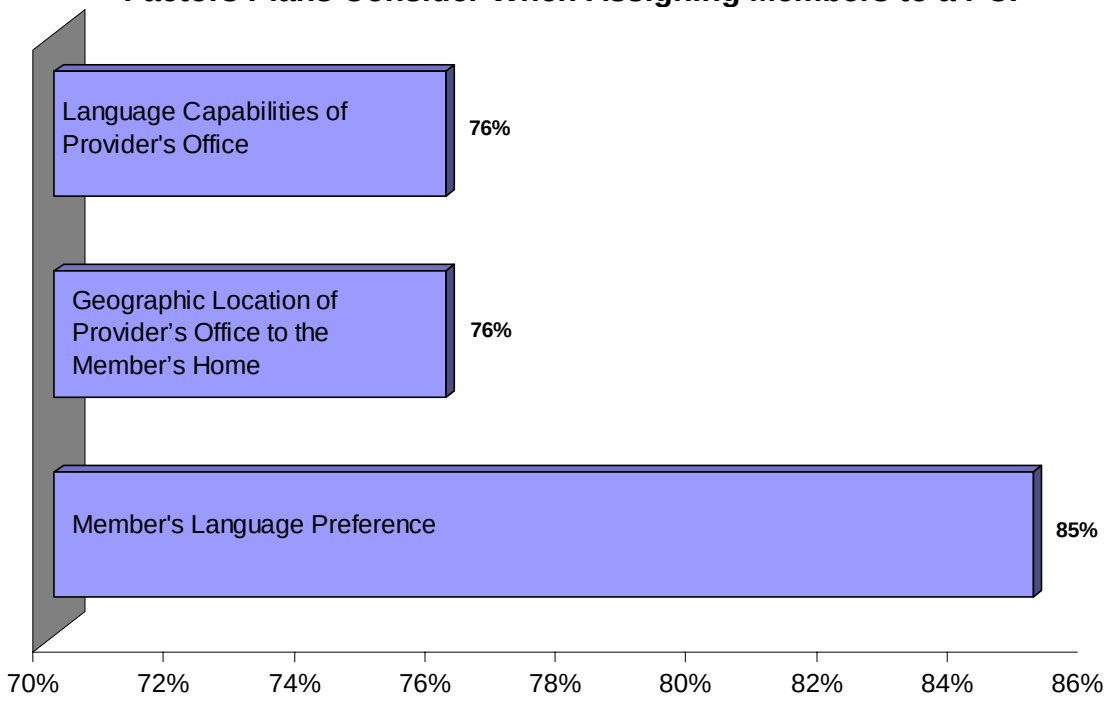
A HFP member can go to the HFP website, www.healthyfamilies.ca.gov to search for a provider by name, specialty, gender, language and proximity to the member's home or any combination of these criteria.

The other main factors that plans consider when assigning members to a PCP are geographic location of provider's office to the member's home, and the language capabilities of a provider's office as shown in Chart 8.

[10] Exclusive Provider Organizations (EPO) plans do not require members to select a PCP.

Chart 8

Factors Plans Consider When Assigning Members to a PCP



Source: 2006-07 HFP C&L Survey

Documenting Member Requests or Refusal of Interpretive Services

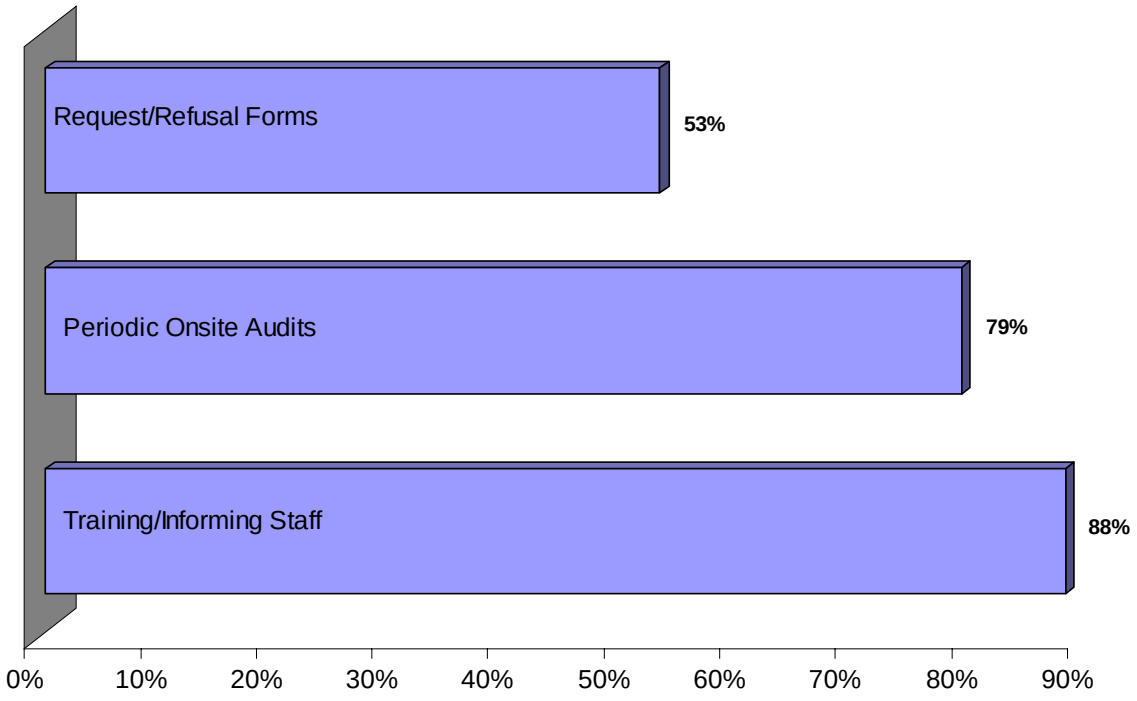
All HFP plans require providers to document member requests or refusal of interpretive services in the member's medical record.

The vast majority of plans (88%) report that they train providers on the need to document language assistance requests. Nearly 80 percent (79%) of plans report that they conduct periodic on-site audits to check whether providers have documented language preference or assistance in the member's file. About half (53%) of the HFP plans use a form to document the request or refusal of interpretive services. See Attachment B for a sample form documenting request or refusal of interpretive services.

Chart 9 identifies the methods plans use to ensure providers document member requests or refusals of interpretive services.

Chart 9

Documenting Request or Refusal of Interpretive Services



Source: 2006-07 HFP C&L Survey

Translation of Written Materials

All HFP plans are required to translate the following written materials into Spanish and any other threshold languages[11]:

- Evidence of Coverage (EOC)
- Member Handbook
- Preventive Services Reminders
- Notice of Free Language Assistance
- Marketing Materials and Brochures
- Grievance/Complaints Process
- Notices of Action (including notices pertaining to the reduction, denial, modification, or termination of services)

In addition, some plans translate other materials into Spanish and other threshold languages such as:

- Newsletters
- Member Identification Cards
- Emergency Room Follow-Up Instructions
- Member Satisfaction Surveys
- Provider Directory
- Plan Web Site
- Health Education Materials
- Transportation Resource Guide
- Enrollment Verification Letter and Response Form
- Preventive Services/Immunization Guidelines

Plans must use qualified translators for translating, editing and proofreading written materials. Plans report using a combination of qualified plan staff and translation vendors to translate written materials.

In addition to making written materials available in other languages, the contract requires plans to ensure a sixth grade readability level for member materials. Plans report two primary methods of ensuring readability:

- Flesch-Kincaid Formula[12]
- SMOG Readability Formula (Simplified Measure of Gobbledygook)[13]

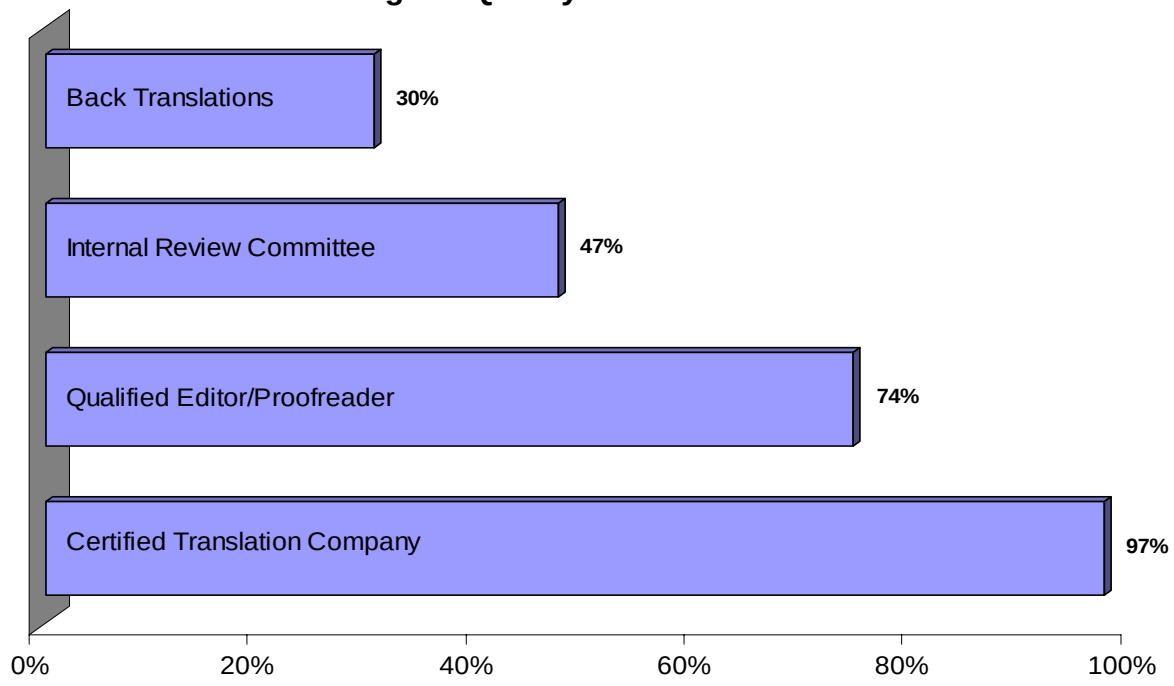
[11] The HFP contract defines a threshold language as a language that represents the preferred method of communication for the lesser of five percent (5%) of a plan's enrollment; or the preferred method of communication for 3,000 members of the plan's enrollment in the program.
[12] The Flesch-Kincaid Formula was developed by Rudolf Flesch and J. Peter Kincaid. It was designed for technical documents and is mostly applicable to manuals and forms, rather than schoolbook text or literary works. This test calculates the U.S. grade level of a text sample based on sentence length and syllable count.
[13] The SMOG was developed by G. Harry McLaughlin and also estimates the years of education needed to understand a piece of writing.

Nearly all (97%) plans report that they ensure the quality of translated materials by contracting with a certified translation company (vendor) that follows a step-by-step translation process. About three-quarters (74%) of plans indicate that after a document has been translated, they utilize a separate qualified translation editor/proofreader to review the document for further accuracy. About half (47%) of plans report using an internal review committee to ensure quality, and one-third (30%) conduct "back translations" where translated material is translated back to its original language for comparison and to ensure accuracy.

Chart 10 indicates methods plans use to ensure the quality of translated materials.

Chart 10

Ensuring the Quality of Translated Materials



Source: 2006-07 HFP C&L Survey

Other methods plans use to ensure the quality of translated materials include:

- Computer technology for producing culturally and linguistically appropriate translation
- Community Advisory Committees to review documents for accuracy of translation and cultural competency.

Innovative and/or Best Practice

Health Net HMO and EPO:	The plan uses specific ethnic consumer focus groups as a focal point for field testing materials as they are being developed.

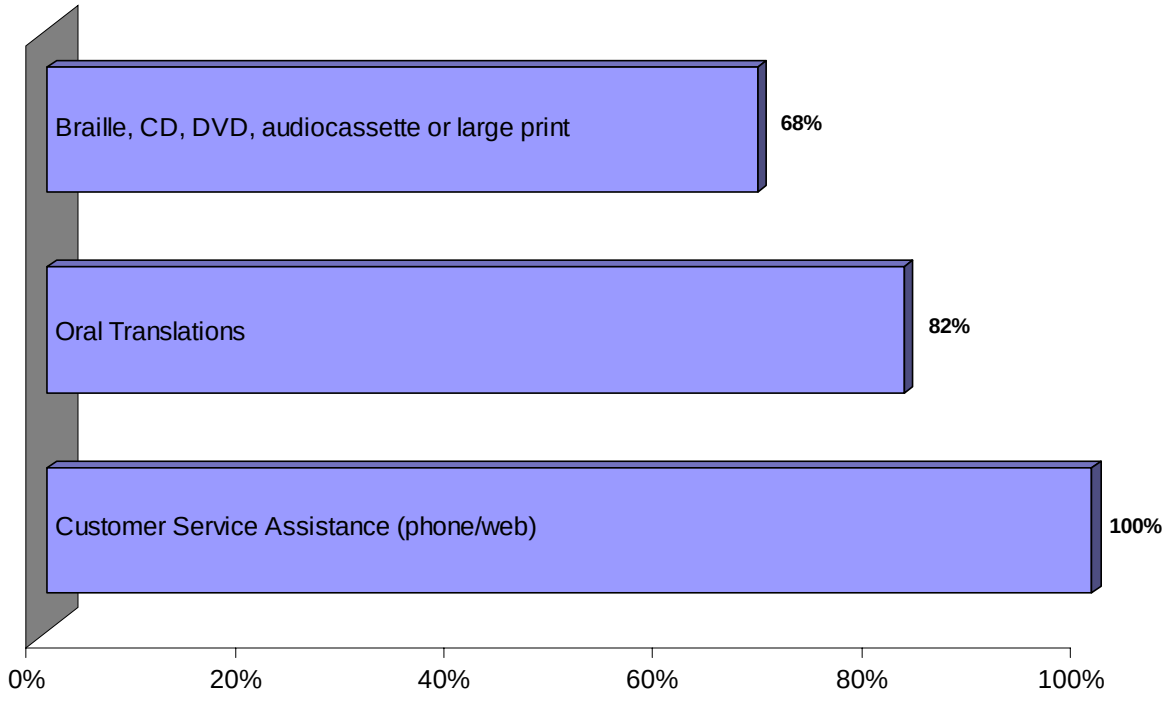
Alternative Formats for Written Materials

Plans must make their written materials available in alternative formats for members who are unable to read translated written materials.

All plans report that members can call the plan for assistance in understanding materials. More than 80 percent (82%) of plans provide oral translation of plan documents and materials. About two-thirds (68%) of plans use alternate formats such as Braille, large print, DVD, CD or audiocassette to communicate plan information to members. See Chart 11.

Chart 11

Access to Alternative Forms of Translated Materials



Source: 2006-07 HFP C&L Survey

Plan Staff and Provider Training

The C&L Survey asked plans to report on the methods they use to inform and train plan and provider staff on interpretive services and cultural competency.

Table 2 summarizes the plans' responses.

Table 2

Information on Interpretive Services and C&L Requirements

Distribute Information	**Documents**	**Other**
	◆ Newsletters ◆ Faxes ◆ Memoranda ◆ Internal Email	◆ Meetings (all-staff, management, departmental) ◆ Training Sessions ◆ Teleconferences ◆ Annual Cultural Awareness Events ◆ New Employee Orientation
Provide Training	**Training Methods**	
	◆ Department and management meetings ◆ Quarterly bulletins ◆ Individualized training ◆ Annual cultural awareness events ◆ Formal workshops ◆ Online learning tool ◆ Informational displays ◆ Collaborating with cultural groups to develop corporate-wide cultural awareness events	
	Training Plan/Provider Staff	
	◆ How to use the Language Line ✓ Customer services department ✓ Call Center ◆ Key Phrases and Words in other languages (ex: what language do you speak) ◆ Certification programs for medical interpreters	
	Other	
	◆ Health education materials in threshold languages made available to providers ◆ Periodic office visits to remind providers of available C&L services ◆ Use of incentives to encourage participation in cultural awareness/competency training	

Source: 2006-07 HFP C&L Survey

Some of the methods plans use to evaluate the effectiveness of provider and staff training include:

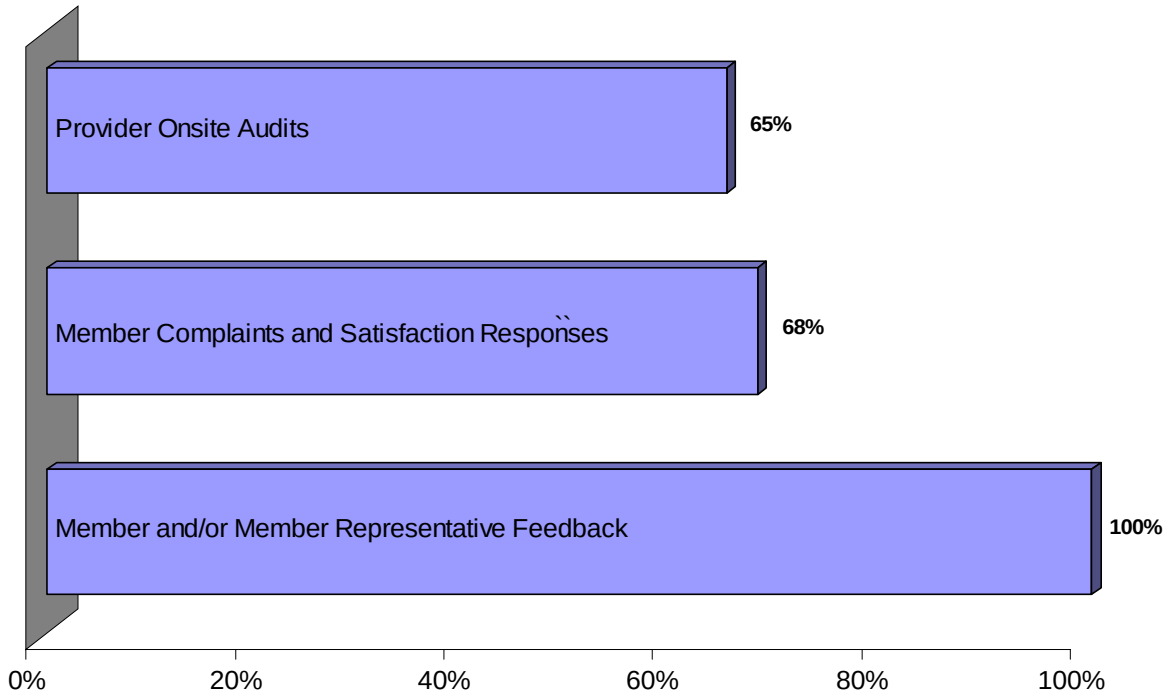
- Audit tool containing a module specific to C&L awareness and sensitivity.
- Post-training survey/evaluation tool.
- Annual member satisfaction survey data.
- Annual performance evaluation of Customer Service staff and their effectiveness in serving LEP members.
- Staff and provider input at meetings, committees, and/or plan events.

Monitoring Language Assistance Services

HFP plans report a variety of methods to monitor their language assistance programs. All plans use member and/or member representative feedback about the plan's language assistance program during meetings, plan events, and committees. About two-thirds (68%) of the plans consider member complaints and satisfaction responses. About two-thirds (65%) of the plans conduct provider onsite audits that check for language assistance program implementation. See Chart 12.

Chart 12

Methods Used to Monitor Language Assistance Services



Source: 2006-07 HFP C&L Survey

Other methods plans use for monitoring their language assistance programs include reviewing the results from member satisfaction surveys such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, and collecting data from subcontractors and vendors on the provision of language assistance services to members.

Such data includes:

- Complaints and grievance data
- Results from "Mystery Caller" programs
- Onsite reviews of subcontractor/vendor, including patient chart audits
- Newsletter and fax blasts with reminders of subcontractor/vendor C&L responsibilities
- Observation of subcontractor/vendor interpreters.

Internal C&L Systems Development

HFP plans are required to develop internal systems that meet the C&L needs of the plan's members. Plans report a wide variety of methods to meet this requirement.

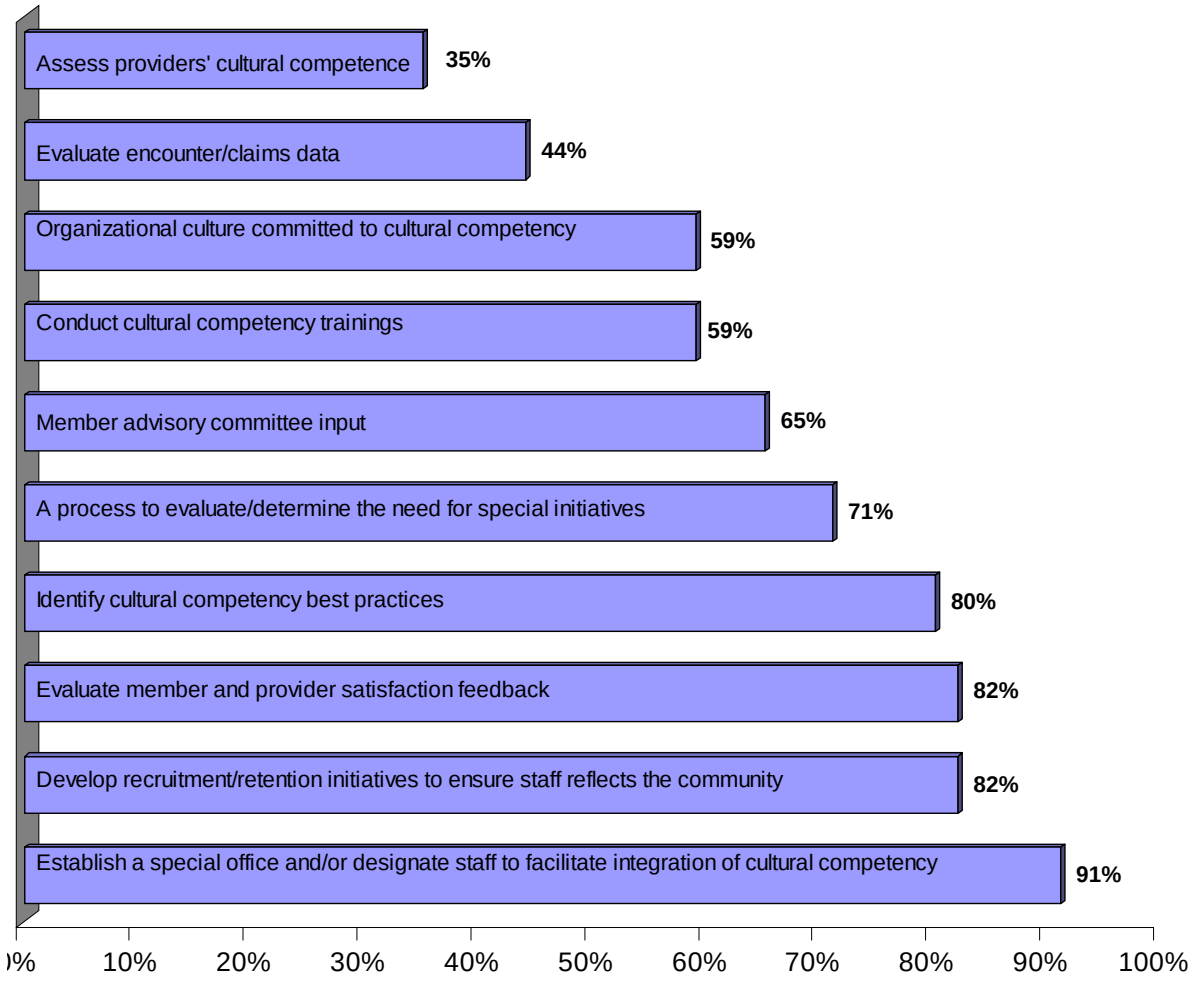
Almost all plans (91%) have established a special office and/or designate staff to facilitate integration of cultural competency. More than eighty percent (82%) of plans develop recruitment/retention initiatives to ensure plan staff reflects the community it serves. Equally, more than eighty percent (82%) of plans evaluate member and provider satisfaction feedback. Eighty percent (80%) of plans work with public/private entities to identify cultural competency best practices in managed health care.

About three-fourths (71%) of plans establish and maintain a process to evaluate and/or determine the need for special initiatives related to cultural competency. About two-thirds (65%) of plans use member advisory committee input. More than half (59%) of plans incorporate cultural competency into the plans' mission, and equally, more than half (59%) of plans educate their staff on cultural competency on a regular basis. More than forty percent (44%) of plans evaluate encounter and claims data to improve C&L internal services/processes. About one-third (35%) of plans assess providers' cultural competence on a regular basis.

Chart 13 identifies a wide variety of internal systems plans use to meet the C&L needs of their members.

Chart 13

Developing Internal C&L Systems



Source: 2006-07 HFP C&L Survey

Innovative and/or Best Practice

Kaiser Permanente (KP): Kaiser Permanente has produced nationally recognized handbooks on culturally competent care for African American, Asian and Pacific Islander, Latino, Lesbian, Gay, Bisexual, and Transgender populations, and individuals with disabilities.

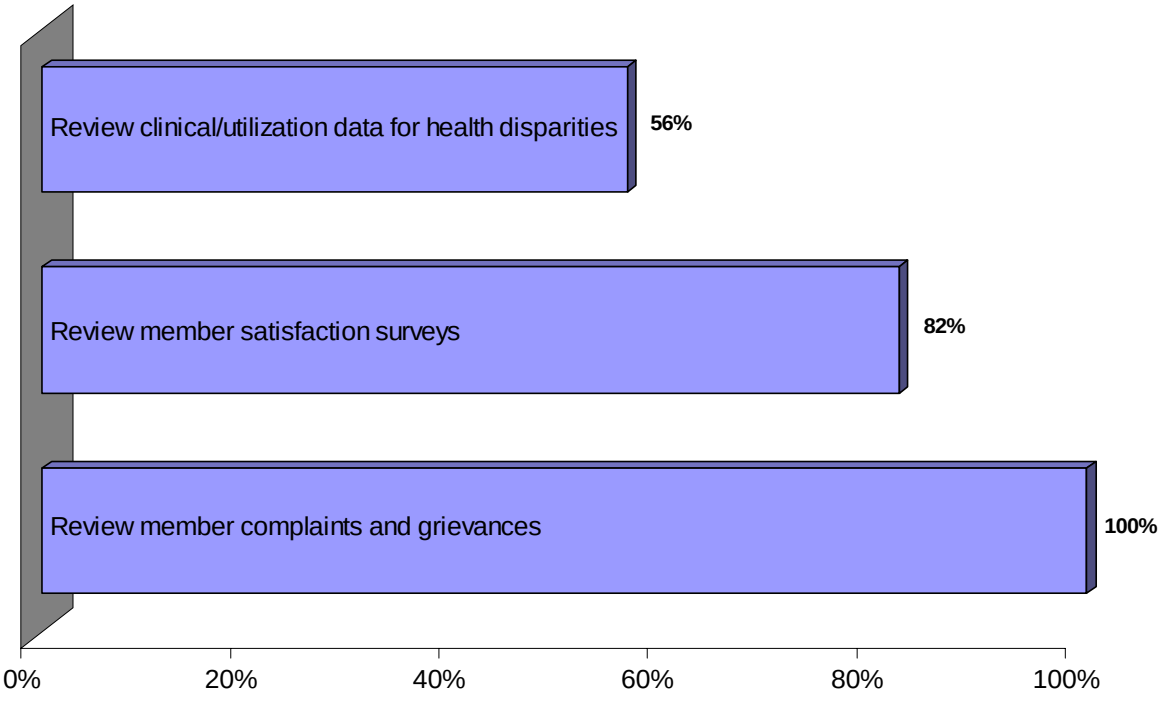
KP also promotes multicultural staff associations that operate throughout KP's California regions. The associations provide a cultural link between KP and the communities they serve. These multicultural staff associations represent KP at local health fairs and other community activities and contribute to culturally competent care handbooks.

Quality Improvement

Plans evaluate cultural and linguistic services and outcomes annually as part of their quality improvement efforts. All plans indicate they review member complaints and grievances, more than eighty percent (82%) of plans review results from membership satisfaction surveys, and more than half (56%) review clinical/utilization data for health disparities. See Chart 14.

Chart 14

Evaluation of C&L Processes



Source: 2006-07 HFP C&L Survey

Plans report using other data to evaluate their C&L services and the outcome of their C&L activities such as:

- Feedback from providers and members that attend or complete health education classes
- Reviews of provider communication/relation satisfaction surveys.

Plan Strategies to Address Identified Health Disparities

The C&L Survey asked plans to identify any strategies they were using to address identified health disparities. Below are some innovative strategies.

Innovative and/or Best Practices

Community Health Group & L.A. Care:	HEDIS 2004 Asthma data showed particularly poor rates of compliance with guidelines for members speaking Cantonese, Spanish, English and Armenian. L.A Care identified six zip codes where these groups were concentrated and compliance was poor. L.A. Care developed a pilot project whereby pharmacists used telephonic interpretation services and specifically developed materials during the pharmacy consultation with plan members. Dual handset or headsets allow the pharmacist to communicate effectively with the member, via an interpreter, maintaining eye contact and talking to the member not the phone. The main objective of this study was to increase controller medication use by 10% for targeted members. The goals of the pilot project are to increase appropriate use of asthma medications, reducing Emergency Department (ED) visits, and achieve better control of targeted patients' asthma condition. L.A. Care will produce a report containing the results of the pilot program.
San Francisco Health Plan:	The plan worked closely with clinics serving Chinese speaking members to improve the rate of adolescent well visits. The plan also promoted an on-line CME course for providers serving this community to increase Chlamydia screening among their Chinese population for which there was an identified disparity.

Blue Cross of California (BCC):	To increase asthma controller medication compliance, BCC Pharmacy and Quality Improvement departments researched ethnic group differences in the utilization of asthma pharmacist consultations. Members are served by a plan-wide asthma management program, as well as services through community interventions designed to meet the needs unique to the community where the member resides. A program component available to all communities is the point-of-service asthma pharmacy consultation in which the pharmacist is prompted by a "pop-up" screen when a qualifying member fills an asthma prescription. Results indicate that asthmatics who received an asthma consult were more likely to have filled at least one appropriate controller medication in 2004 than asthmatics who did not receive a consult. The pharmacy consult resulted in a statistically significant increase in asthma controller medication compliance for African Americans and Hispanics.

How MRMIB Uses the C&L Survey Information

MRMIB staff will work with HFP plans that are not meeting the C&L needs of HFP members to:

- Discuss the issues and/or barriers that limit the plans' ability to meet the C&L requirements.
- Identify any new strategies the plans have implemented to address the issues and/or barriers.
- Share strategies from other plans, including some of the innovative or "best practices" described in the report, to help plans improve their performance.
- Develop a corrective action plan and timeline that describes how these plans will better meet the C&L requirements and better serve their LEP members.
- Monitor the implementation of the corrective action plan.

Conclusion

This report summarizes the cultural and linguistic services provided to HFP members in 2006-07 as reported by HFP health, dental and vision plans. As noted throughout the report, a number of plans have developed innovative methods to address the C&L needs of limited-English proficient members. However, there are some plans that still fall behind in meeting basic language access requirements.

As noted above, MRMIB staff will work with the HFP plans to continue to evaluate and improve upon services provided to HFP members with limited-English proficiency.

Attachment A: C&L Survey for FY 2006-07

CULTURAL AND LINGUISTIC SERVICES REPORT

For Services in FY 2006-07

Plan Name:

1) How does the Plan identify the language preference of its members?
Check all that apply.

a. ☐ from HFP member enrollment data
b. ☐ during the welcome call
c. ☐ other (explain):

2) When a member has not selected a Primary Care Physician (PCP) what considerations are taken when using physician auto assignment?
Check all that apply.

a. ☐ member language preference
b. ☐ language capabilities of provider office
c. ☐ provider location
d. ☐ other (explain):

3) How does the Plan inform its members of the availability of no cost interpretive services?
Check all that apply.

a. ☐ welcome call/welcome package
b. ☐ evidence of coverage (EOC)
c. ☐ other (explain):

4) What information does the Plan provide to members regarding interpreter services?
Check all that apply.

a. ☐ availability of interpreter services to members at no charge
b. ☐ right <u>not to use</u> family members, friends or minors as interpreters
c. ☐ right to request an interpreter, during discussions of medical information such as diagnoses of medical conditions and proposed treatment options, and explanations of plans of care or other discussions with providers
d. ☐ right to receive member materials in the Plan's threshold languages
e. ☐ right to file a complaint or grievance if linguistic needs are not met
f. ☐ other (please explain):

5) How does the Plan provide 24 hour interpreter services to HFP members?
Check all that apply.

a. ☐ face-to-face interpreters
b. ☐ telephone language line
c. ☐ member services telephone/web system
d. ☐ other (explain):

6) Does the Plan provide "Interpreter Request Cards" or "I Speak Cards"?

☐ Yes
☐ No

7) Explain the process used by providers and members to notify the Plan when interpreter services are needed.

i. for non-medical points of contact
ii. for medical points of contact

8) When has the provision of face-to-face interpreters not been feasible at medical points of contact?

Explanation:

9) The Plan agrees that the use of family members or friends as interpreters shall not be required or encouraged. Explain the steps used by the Plan and providers to encourage the use of qualified interpreters.

10) The Plan also agrees that minors shall not be used as interpreters except for only the most extraordinary circumstances. Please describe any extraordinary circumstances when it was necessary to use minors as interpreters.

11) Explain the process the Plan utilizes to inform/train staff on:

i. interpretive services
ii. cultural competency

12) How does the Plan assess the Cultural and Linguistic needs of members?

Check all that apply.

a. ☐ cultural and linguistic needs survey/Group Needs Assessment (GNA) annual update
b. ☐ member input during Plan meetings, events and/or committees
c. ☐ other (explain):

13) How does the Plan monitor its language assistance program (interpretive services)?

Check all that apply.

a. ☐ review of customer complaints and satisfaction responses
b. ☐ member/representative input at Plan meetings, events, committees, etc.
c. ☐ findings from provider onsite audits conducted by the Plan
d. ☐ other (explain):

14) How does the Plan ensure subcontracted providers and/or vendors meet HFP cultural and linguistic services contractual requirements?

Explanation:

15) Does the Plan and/or subcontractor employ or utilize community based organizations to interpret for members?

☐ Yes (explain):
☐ No

16) How does the Plan make providers aware of members' language preferences?
Check all that apply.

a. ☐ monthly member eligibility reports with language preference
b. ☐ new enrollee notification with language preference
c. ☐ other (explain):

17) Does the Plan instruct providers in its network to record the language needs of members?

☐ Yes, explain the process:
☐ No, explain:

18) Does the Plan instruct providers to document in the medical record Requests/Refusals of language interpretive services?

☐ Yes, explain the process:
☐ No, explain:

19) How does the Plan ensure providers comply with question eighteen?
Check all that apply.

a. ☐ train its providers on the need to document a request or refusal of interpreter services
b. ☐ supply providers and their staff with Request/Refusal forms for interpreter services
c. ☐ supply providers and their staff with chart labels identifying member language needs
d. ☐ implement an incentive program to reward provider offices that affirmatively attempt to identify language needs of LEP members and record them on the medical charts
e. ☐ conduct reviews of providers' medical records during periodic audits and/or facility site reviews to check for documentation of the request for or refusal of interpreter services
f. ☐ provide other technical assistance to providers (please explain):
g. ☐ other (explain):

20) At what non-medical and medical points of contact does the Plan ensure language access for its members?
Check all that apply.

a. ☐ member/customer service
b. ☐ provider office reception
c. ☐ appointment services
d. ☐ member orientation sessions
e. ☐ other (please explain):

21) What methods are used by the Plan to ensure language access at the points of contact checked above?

Check all that apply.

a. ☐ hire staff with conversational fluency in multiple languages
b. ☐ hire staff with bilingual fluency in medical terminology
c. ☐ train staff to take or assist with gathering information for an accurate medical history with culturally related consent forms
d. ☐ dictionaries and glossaries for interpreters
e. ☐ give provider staff consistent interpreter training by experienced and properly trained interpreters
f. ☐ periodically assess the language proficiency of the Plan's identified medical and non-medical staff that have patient contact
g. ☐ conduct audits of provider sites to confirm ongoing language capabilities of providers and staff
h. ☐ supply other technical assistance to providers (explain):
i. ☐ other (explain):

22) Which tools does the Plan use to report the <u>on-site</u> linguistic capabilities of providers and provider office staff to members?

Check all that apply.

a. ☐ written "hard" records
b. ☐ electronic database
c. ☐ provider directory
d. ☐ website
e. ☐ other (please explain):

23) How does the Plan verify the proficiency of providers who indicate they are bilingual?

Explanation:

24) List the Plan's threshold languages:

25) For each of the member materials listed below, please list the non-English languages in which the Plan translates the materials. Please note that the information provided will be included in comparative charts in the Healthy Families Program brochure or other public documents (Reference: HFP Contract, Exhibit A, Item III.C.2.a).

DOCUMENT	**LANGUAGE/s**
Evidence of Coverage or Certificate of Insurance	
Member Handbook and information on how to use the member handbook	
Welcome Letter	
Newsletters	
Preventive Services Reminders	
Health Education Material	
Disclosure Forms	
Consent Forms	
Letter and notices reducing, denying or terminating services or benefits *(Notice of Action)*	
Forms	
Letters and notices requiring a response from the member	
Patient satisfaction survey (ex: CAHPS)	
Notice of free language assistance	
Provider listings	
Marketing materials	
Complaints and grievance materials	
Emergency Room follow-up	
Any documents required by law or affecting any legal right or responsibility (ex: Disclosure Forms, etc.)	
Other (please describe):	

26) How does the Plan ensure a sixth grade readability level for member documents (including translated documents)?

Explanation:

27) What is the Plan's process for translation of documents?

Explanation:

28) The Plan agrees that the translation process shall include the use of qualified translators for translating and editing, proofreading and professional review. Which of the following activities does the Plan undertake to ensure the quality of translated materials?

Check all that apply.

a. ☐ contract and use of certified translation companies that follow a step-by-step translation process
b. ☐ perform back translation of material into its source language for comparison and accuracy by certified translation vendors other than the original translator
c. ☐ have an internal review committee that includes a medical and/or legal "professional reviewer" who reviews translated materials for cultural appropriateness
d. ☐ proof-read and edit of documents by a separate qualified translation editor/proof reader
e. ☐ use of computer technology as part of the process for producing culturally and linguistically appropriate translation
f. ☐ other (please explain):

29) Which of the following activities does the Plan use to ensure that members who are unable to read the written materials that have been translated into non-English languages have an alternate form of access to the contents of the written materials?

Check all that apply.

a. ☐ inform LEP members, during the welcome call, of the Plan's language assistance services
b. ☐ encourage members to call the Plan if they need help in understanding any of the Plan's written materials
c. ☐ provide an oral translation of the material in a member's preferred language or arrange for this to be done by a competent interpreter service
d. ☐ make the content of written materials available in alternative formats such as Braille, CD, and audio cassette
e. ☐ other (please explain):

30) The Plan shall provide initial and continuing training on cultural competency to staff and providers. Please list training sessions for the 2006-07 benefit year (include title, date, duration, and goals):

31) How does the Plan obtain evaluation/feedback on cultural competency training?

Check all that apply.

a. ☐ post-training satisfaction surveys
b. ☐ discussion of training effectiveness at Quality Improvement meetings
c. ☐ other (please explain):

32) Which of the following activities does the Plan undertake in developing its internal systems to meet the cultural and linguistic needs of the members?

Check all that apply.

a. ☐ incorporate cultural competency in the Plan's mission
b. ☐ establish and maintain a process to evaluate and determine the need for special initiatives related to cultural competency
c. ☐ develop recruitment and retention initiatives to establish organization-wide staffing that is reflective and/or responsive to the needs of the community
d. ☐ assess the cultural competence of Plan providers on a regular basis
e. ☐ establish a special office or designated staff to coordinate and facilitate the integration of cultural competency guidelines
f. ☐ distribute communication tools to staff relating to cultural competency issues (e.g., those tools generally used to distribute other operational policy-related issues)
g. ☐ participate with government, community, and educational institutions in matters related to best practices in cultural competency in managed health care to ensure an outside perspective is maintained in Plan policies
h. ☐ maintain an information system capable of identifying and profiling cultural and linguistic specific patient data
i. ☐ evaluate the effectiveness of strategies and programs in improving the health status of cultural-defined populations
j. ☐ evaluate satisfaction feedback from member surveys, staff, and/or providers
k. ☐ evaluate encounter/claims data to improve services/processes
l. ☐ evaluate input from member advisory committees
m. ☐ other

33) Explain any of the activities checked above.

34) As part of the Plan's quality improvement efforts, does the Plan utilize the following data to evaluate cultural and linguistic services and outcomes of cultural and linguistic activities?

Check all that apply.

a. ☐ member complaints and grievances
b. ☐ results from membership satisfaction surveys
c. ☐ utilization and other clinical data that may reveal health disparities as a result of cultural and linguistic barriers
d. ☐ other (please explain):

35) For the items checked above, does the plan utilize primary language, race and ethnicity data to assess quality of care and monitor health disparities?

Explanation:

36) Has the plan implemented specific strategies or programs to address identified health disparities?

Explanation:

37) Attach the following cultural and linguistic related information

a. A list of linguistically and culturally appropriate providers and clinics available
b. A list of interpreter agencies used
c. A list of culturally and linguistically appropriate community services and programs used for referrals of members
d. Policies and procedures regarding access to interpreter services

Additional Information/Comments:

PREPARER'S INFORMATION

Name and Title:

Mailing Address:

E-mail: Phone #:

Attachment B: Sample Request or Refusal of Interpreter Services Form

SAMPLE REQUEST OF REFUSAL OF INTERPRETER SERVICES FORM

Date: _____ Name of Member:_____

Address: _____ Primary Language: _____

Race: _____ National Origin: _____

Did the Member Accept Interpreter Service? _ YES _ NO

If no, advise the member that they can change their mind at any time and request an interpreter.

Give reason for refusal of interpreter services:
_____

If yes, advise the member that they may, at any time, request another interpreter. Advise the member that if communication with the chosen interpreter is not effective, the plan/provider employee may, at any time, change the interpreter.

Please indicate below what interpreter services were utilized:

___ Telephone Interpreter Services ___ In-Person Interpreter

Interpreter Vendor Name: _____ Name of Interpreter: _____

Name of Other Interpreter Used: _____

Relationship to Member: _____ Language Interpreted: _____

Purpose for Member contact with provider/plan: _____

Employee name and job classification handling Member case:
_____

Note to plan/provider employee…You must place the following notation on the outside of the member file to ensure that interpreter services are obtained before doing business with the member, “NEEDS INTERPRETER SERVICES”, Language: _____